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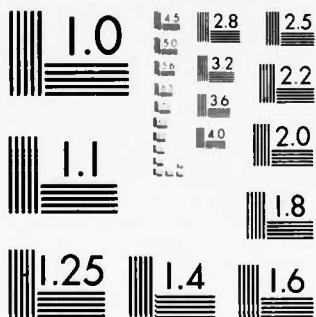
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GOVERNMENT AND HEALTH POLICY

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February 1982

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PREFACE

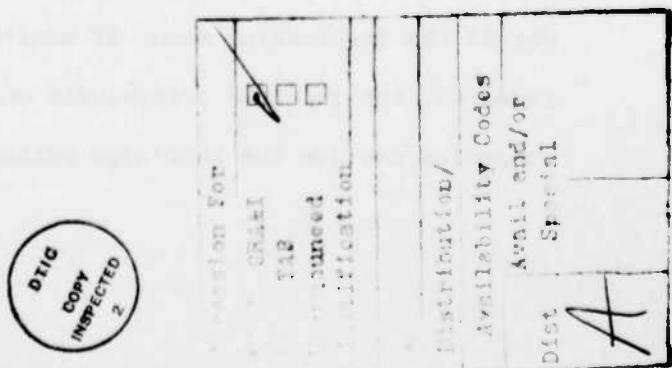
This paper formed the basis for a talk given on January 16, 1982, at the Annual Meeting of the Benjamin Rush Society in Los Angeles, California.

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A discussion of government's effects on health policy may seem odd at first glance. After all, isn't all health policy determined by the government? After some reflection on this issue, however, the opposite conclusion may emerge. Perhaps the government has nothing at all to do with health policy! To understand how such a conclusion could even be entertained, let alone adopted, requires an excursion into the structure and functions of government, and an analysis about how health policy (or any other government policy) is set.

THE MECHANISMS OF POLICY

No discussion of government policy can be complete without considering first the means by which policy can be effected. Basically, government policy consists of attempts to change the amounts (and possibly the types) of things that people (and organizations) would otherwise do on their own. Four basic mechanisms suggest themselves to accomplish such goals: (i) direct government purchase of services or commodities (and subsequent provision to part or all of the population); (ii) changing the prices of services or commodities faced by individuals or firms (either taxes or subsidies); (iii) changing the incomes of persons or firms to allow them more (or less) general purchasing power; and finally, (iv) requiring that certain things be done (or not done) by individuals or organizations--otherwise known as regulation. Each of these deserves at least a slightly expanded discussion.



Government Purchase, Production, or Provision

Governments directly purchase or produce a vast array of services and goods, ranging from airplanes and tanks (for national defense) to houses (for low-income housing programs), to reservoirs (to store water for irrigation of private lands).

Government purchase or direct production has been a common tool in health policy, most prominently in biomedical research. When the National Institutes of Health were formed several decades ago, a vast revolution in health policy took place. For better or worse, the NIH launched our nation on a path of technological fixes to disease processes, a path which permeates many other aspects of health policy. Other direct government provision and purchases of note in health policy include the VA hospital system, the Public Health Service, and (probably more important) the vast array of state and local government hospitals caring for the indigent and providing the bulk of hospitals in which mental illness is treated.

Interestingly, the important aspects of such government interventions are not the purchases themselves, but rather the choices involved in the disposition of the goods and services acquired. The government can (and must!) define some form of property rights to those goods and services, so that they may be used by the intended recipients. And in defining those rights, the government changes consumption patterns.

The issue of rights to government-owned goods and services looms as one of the fascinating areas of health policy analysis. In biomedical research, the issue is effectively one of patent law--which persons or companies can use the knowledge gained through government-paid studies.

Typically, the logic for government intervention is that information is a "public good," which, once acquired, should (to maximize social well-being) be distributed to all comers at its marginal (incremental) cost of production. By this view, once a new idea is proven correct, it should be distributed for the cost of a journal reprint and a stamp, with no attempt made to recoup the costs of the research leading to the idea or its proof of correctness. This, indeed, is the principal justification to many for government intervention into such areas as biomedical research.

In other areas where government policy is achieved through purchase of services or goods, there appears primarily to be a rationale of helping those who are in (or moving into) a period of reduced income. State and local hospitals, nominally available to all within the geographic boundaries of the government body, have fundamentally been justified as providing health care for the indigent. Thus, to establish a right to use these services, one must often "prove" indigency or pay for the service directly.

Changing Prices of Goods and Services

Another common and important tool of government policy is to alter the relative prices faced by private buyers when seeking goods and services. The mechanisms available are taxes (to raise prices) and subsidies (to lower them). Except for the direction of change, they have equivalent effects, and may be analyzed similarly.

It is ironic that most people think of taxes as devices to raise revenue (for example, to provide for the purchase of biomedical research

by the government). But the economist sees taxes fundamentally as devices to change prices, and hence behavior. The revenue-raising aspects of a tax are often incidental, and occasionally bothersome.

Underlying this notion of taxation is a long series of economic models and empirical support showing that people reduce their consumption of a good when its relative price rises, and increase their consumption when the relative price falls. Thus, taxation of alcohol and tobacco (which were, until the 20th century, the principal forms of revenue-raising in the U.S.) can be thought of as powerful tools of health policy. As those taxes rise, consumption of these harmful substances will fall. It is probably neither desirable nor possible to tax such activities to extinction--evasion limits the possibilities for using taxes to achieve such policy goals--but taxation nevertheless forms a powerful tool in the kit of the health policy planner.

Tax/subsidy schemes have been common in health policy in many areas. The "sin taxes" previously mentioned are perhaps most prominent in the broad sweep of history in the United States, but such recent innovations as Medicare, food stamps, housing subsidies, medical school subsidies and loans to students, and tax-exempt status of hospitals are but a few examples of government changing input or product prices.

Perhaps the most important, in terms of effects on the health care sector of our country, has been the tax treatment of private medical insurance purchases (and private health care purchases) in the U.S. income tax system. For decades, health insurance premiums paid by employers on behalf of their employees have not been treated as taxable income. This provides employers with strong incentives to pay employees

with health insurance, rather than with cash, because the employee gets a larger after-tax compensation for the same amount of employer payment in wages. Paying workers in this way increases profits of firms and is thus quite popular. Because of our progressive personal income tax structure, the incentives to do this increase with the income level of the employee. As a consequence, there is a strong relationship between income and the extent of private health insurance provided by employers to employees and their families, and a large overall increase in the amount of health insurance held in our country (Mitchell and Phelps, 1976). This, in turn, increases the amount of medical care purchased by individuals, increases the pressure on the health care sector, drives up prices higher than they would otherwise be, and possibly even changes the styles of medical care practiced in our country.

The tax subsidy to health insurance is so large that it is now literally cheaper for many people to buy their aspirin through insurance than to buy it privately, because the tax subsidy is larger (in percentage terms) than the administrative costs of the insurance plan.

Even in acute medical care, the price faced by the consumer/patient has large effects on the amount, and probably the type, of medical care chosen (Newhouse et al., 1981). As people become fully insured for health care expenses, decision rules used in medical treatment change in subtle but important ways. The "market test" facing new procedures or products is not "Is this worth its cost to society?" but rather "Is it worth anything at all?" (This is true because the cost to the patient, at the time of decisionmaking, is nothing at all.) The effects of more insurance, coupled with the infusion of technology from the biomedical

research funded through the NIH, may have led us into a world where we are pursuing medical applications of new technologies in highly unproductive paths and ways, compared with the cost of resources used. If so, and if this is an unintended consequence of past health policy, then (as will be discussed below), one should expect either reversal of past policies in these areas or additional government policy intended to offset these unwanted consequences.

Changing Incomes of Persons

For completeness, we should consider changes in incomes a tool of health policy as well as changes in prices, although it has not been a common tool employed in the past. A strong positive association of income and health (measured by life expectancy, infant mortality, etc.) can be demonstrated readily when looking across countries (Newhouse, 1977). In part, the same appears true when looking within a country (such as the United States), but to a less striking degree. In fact, cross-sectional studies within the U.S. show eventually that health status declines as income rises to very high levels (Grossman, 1972). While some researchers believe that this is due to increased consumption of health-reducing activities or the general stress associated with producing that high income (Fuchs, 1974), this remains one of the interesting puzzles in health policy. Can we increase an individual's health by simply giving him more money? In part, our society has proven reluctant to take such steps, choosing rather to change prices or provide free medical care, partly on the belief that the individual will not make "the right" choices with increased income. And this paternalism

increases markedly when the individual becomes classified as mentally incompetent, whether through the paradigm of mental illness or from onset of the consequences of aging.

Regulation of Behavior

Neither time nor space permits a full cataloging of the dimensions of regulation in health care policy--laws and rules enacted to require people to do certain things, to prevent them from doing other things, or change the way in which certain things are done. A few examples portray the dimensions of regulation: The FDA (to control which drugs may be sold by corporations); medical licensure (to determine who can treat other individuals and how such treatment is to be carried out); laws making prescription drugs inaccessible to private purchase by individuals without the intervention of a licensed medical practitioner; prohibitions against the use of narcotic and hallucinogenic agents; control of the asset/debt structure of health insurers; mandatory immunizations under certain circumstances (e.g., overseas travel); and most recently, a host of regulations designed to reduce the costs of medical care, including (in various incarnations), Regional Medical Programs, PSROs, restrictions on hospital construction, restrictions on acquisition of medical equipment, restrictions on payments made by public insurers to medical providers, and requirements that employers offer the choice of a prepaid medical practice plan to employees (in lieu of insurance) whenever possible.

HEALTH POLICY TOOLS AND HEALTH POLICY OUTCOMES

This is indeed an impressive array of tools available to those desiring to set health policy! With these tools, and others left unmentioned or still undiscovered, it appears possible to accomplish virtually anything a government could desire in health care policy. It would appear that the health policy planner would be constrained only by his imagination and his heart's desires. But this is simply not the case.

Health policy, like any other area of public intervention in private lives, is eventually set in an arena where competing ideas and competing forces meet, compromise, struggle, and change through time. Health policy is neither set by health planners nor by "the will of the people," for there is no single "will." Interest groups compete, each with some power to affect policy choices, and each of which must be accommodated in the eventual equilibrium reached by the government body. This process of accommodating interests and protecting rights in the status quo determines policy. Those with stronger political power can move the government's choices closer to their own, but they cannot capture and hold a government forever against the competing interests of others. Health policy is a compromise among the wills of the peoples.

Another important limit to government policy is that the link between policy and individual behavior is sometimes weak, often poorly understood, and difficult to enforce. Government policy must compete with, and is constrained by the normal forces of market operations in our society. This, and the inherent checks of a vote-based government, provide important (and probably definitive) boundaries on the potential for government to affect health outcomes through health policy, and even

severely limit the available choices of policy tools themselves.

The Example of National Health Insurance

Two examples of longstanding health policy demonstrate these ideas: National Health Insurance (NHI) and policies affecting physician location. National health insurance has been "just a year away" since the early 1930s. The demand for a comprehensive, universal system of health insurance has been voiced in nearly every congress, and during every presidency, since FDR. These calls for NHI failed because there was not a sufficient political consensus for their support. Organized labor has long pushed for NHI. Organized medicine has long opposed it. Both sides have succeeded and failed at the same time. What transpired was a gradual evolutionary compromise, leading to something akin to NHI, but without the uniformity or overall compulsion that such a plan would entail. And this compromise was reached because neither side of the global debate on NHI could achieve sufficient political support from other members of our society to sway the government policy entirely in their direction. Instead, we find tax subsidies for insurance (which largely benefit higher income persons), Medicare and Medicaid (which largely benefit lower income persons), the VA system, Public Health Service hospitals, local hospitals, government mental health clinics, and (now!) regulation attempting to control the costs deriving from these former choices.

The choices of insurance methods (tax subsidies, special targeted government insurance and direct provision of medical care) arose largely because of the inherent desirability in the United States of self-help

and individual control of destiny. Allowing people to choose their own health insurance is the only politically acceptable cornerstone of a "NHI policy" in such a society. Yet the pressure to help those with lower incomes (in part because such low-income people are a powerful voting block) provides a long history of alternatives to NHI for those people, beginning with local government hospitals, the Kerr-Mills bill of the early 1960s, Medicare and Medicaid, and a host of other targeted programs. And the recent attempts to promulgate a NHI plan in the U.S.--authored by legislators from a wide range of the political spectrum--continue to use the current employer-based insurance as the central part of NHI (by making it mandatory for employers to provide such insurance for all employees) and picking up the unemployed families through direct government plans, sometimes replacing, sometimes retaining Medicare. Such solutions accommodate existing interests quite well, yet even these have proven not sufficiently popular to reach political consensus. If any NHI eventually prevails, it will almost certainly use such mechanisms as a base.

The other side of this approach is that no central control of health-care expenditure is available, and this forms the second part of the NHI story. As we have proceeded to our decentralized alternative to NHI, the combination of private insurance (subsidized by taxes) and NIH-supported biomedical research has led to an explosion of medical technology which has in recent years become more costly than society appears willing to tolerate. The inevitable consequence must either be a reversal of past events (eliminate the tax subsidies, eliminate the biomedical research) or take alternative steps to control the rising

costs. Unless some underlying change in political power arises, health policy (like other government policy choices) protects peoples' rights in the status quo among its other goals. The choice of eliminating the tax subsidies and the NIH has not been considered: too many people had acquired "rights" under these systems. Thus, an incremental approach to dealing with the rising costs, nibbling away at the edges, compromising with affected groups at every step along the way, has been the inevitable choice of policy planners. The proliferation of cost-containing ideas in various states, and through sequential federal programs, attests to the lack of full understanding of how to accomplish this. Yet even the obvious difficulties in achieving control through these mechanisms demonstrate how powerfully the affected parties have been able to protect their rights to the mechanisms causing the increasing expenditures and prices--the earlier subsidies to insurance and biomedical research. Only in an administration with such sweeping changes as the Reagan administration has there been serious consideration of cutting either of these past federal policies, and even then only incrementally and with a deep bow to the embedded rights of affected groups.

The Example of Medical Manpower Policy

Another public policy thrust of interest is the longstanding attempt to deal with both geographic and specialty-choice physician distribution issues in our country.^[1] The government has proposed and implemented a whole variety of federal programs to induce (or require)

^[1] The problem is not unique to the United States. Even a nation with powers of compulsion as large as the Soviet Union is persistently faced with doctors unwilling to practice in rural areas.

physicians to practice in rural areas or in specialties thought to be undersubscribed by health planners. Loans to medical students tied to the promise of rural practice are one policy tool used. Subsidies to medical schools contingent on altering their mix of graduates are another. The Public Health Service and the Health Service Corps are direct attempts to influence distribution of physicians through government purchase and provision of services. Yet, startlingly, the most potent force yet leading to more rural practitioners is the one rejected in all health planning by government--the simple market force of supply and demand (Schwartz et al., 1980). The notions that supply responds to demand in health care are disturbing to many practitioners, but they are nevertheless real and important. The high rate of psychiatrists locating in the Washington, D.C., area is not unrelated to the longstanding provision of psychiatric benefits in federal employees' insurance. And most startlingly, the massive increase in medical school graduates in the past decade has forced literally thousands of young practitioners to seek patients in areas previously scorned--the rural communities of our nation. The diffusion of physicians of all specialties into the rural areas in the 1970s and '80s is one of the truly compelling pieces of evidence both that market forces are present and that they present powerful restraints on the choices and consequences of health policy (Schwartz et al., 1980).

CONCLUDING REMARKS

These examples do not prove, but perhaps illustrate, the theme presented at the beginning of this paper: government does not determine

health policy but rather provides a vehicle for expression of the collective, sometimes combative, and always compromised interests of parties in our society which are affected by health policy choices. A government policy planner who did not correctly read and accommodate those competing interests would soon be replaced by one more adept at his craft. The ability of special interest groups to capture the government for their own gain is always tempered by the competing interests and pressures of others. Perhaps for these reasons, the eminent economist John Maynard Keynes once noted that, "The power of vested interests is vastly exaggerated compared with the gradual encroachment of ideas." One could only add that even the power of ideas is eventually limited by the behavioral choices made by people, always in response to incentives provided by policy, and usually (but not always!) within the boundaries prescribed by regulation. These limits imply that the role of the government in setting health policy may, in the long run, be very small indeed. Government may best be thought of as implementing policy, but the competing wills of the peoples determine policy choices.

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